PUI:_____

COVID-19 Screening and Case Form

CDC-EOC at 770-488-7100

Epi: _____ Date: _____

Patient Name:_____ DOB:_____ Age:_____ Sex: □ Male □ Female **Race:_____**

Patient Phone Number: _____ or Emergency Contact Name/Number:_____

Address (if approved):_____ City: _____ Parish:_____ Zip:_____

Special Housing: □ Nursing Home □ LTAC □ Group Home □ Military Base □ Correctional □ ICE □ Behavioral/Rehab Center

Name of Special Housing Facility:

Name of Physician:_____ Facility Name:_____ City:_____

Caller/Facility number:_____ If Approved, Physician Email:_____

Hospitalization Status and Symptoms

Hospitalized? □ Yes □ No If yes, Admit date: _____ Discharge date: _____

If Hospitalized, reason/status:_____

Admitted to ICU? □ Yes □ No **ER Visit (Not Admitted)?** □ Yes □ No **Date:_____**

Intubated (Mechanical Vent)? □ Yes □ No **Extracorporeal Membrane Oxygenation (ECMO)?** □ Yes □ No

SYMPTOM ONSET DATE: _____ Date of Symptom Resolution:_____

□ Fever, Temp:_____	□ Cough	□ Vomiting	□ **Abnormal Chest X-Ray**
□ Sore throat	□ Shortness of breath	□ Diarrhea	□ **Pneumonia, specify:_____**
□ Chills	□ Headache	□ Muscle aches	□ Other: _____
□ Abdominal pain	□ Runny nose	□ **ARDS**	

Has testing been done to rule out other respiratory illnesses? □ Yes □ No

Influenza? □ Not done □ Negative □ Positive _____ if performed, □ Rapid Test □ PCR Test (part of RVP)

Respiratory Virus Panel? □ Not done □ Negative □ Positive _____

Blood cultures? □ Not done □ Negative □ Positive _____ **Other? Specify:** _____

Does the patient have any comorbid conditions? □ No □ Yes, check all that apply:

□ Chronic Pulmonary Disease (COPD)	□ Chronic Kidney Disease- if yes, dialysis? □ Yes □ No	□ Diabetes
□ Chronic Liver Disease	□ Immunocompromising condition: _____	□ Obesity
□ Cardiovascular Disease	□ Asthma	□ Other:

Have close contact with a laboratory confirmed COVID-19 case? □ Yes □ No **Name:_____**

Prioritization Questions

Occupation:_____ (Healthcare worker includes nursing home, anything at hospital, dental hygienist, etc.)

Is the patient a healthcare worker? □ Yes □ No **If yes, did they care for a COVID-19 patient?** □ Yes □ No

Location:_____ Last Day Worked:_____ Notes:_____

Has the patient worked or spent time in another high-risk setting such as a school, daycare, medical facility?
□ Yes □ No, If yes, please describe: _____

Has the patient been on a cruise recently? □ Yes □ No If yes, Where/When:

If Case is POSITIVE, confirm information above and answer additional questions:

Where was testing performed? □ State Lab □ Commercial Lab

Does the patient have any contact with high risk settings? □ Yes □ No, if yes, describe:_____

Did the patient have any other medical visits while ill? □ Yes □ No, if yes, describe:_____

Did the patient attend any events/meetings/public gatherings while ill where other individuals would have been exposed?
Describe, including dates:

***Inform the patient that any high risk contacts (elderly, immune-compromised) should be notified of their exposure by the patient or other close contact (person being interviewed) and told to self-isolate and monitor for symptoms.**